An Introduction to Female Genital Cutting

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Introduction:

Hi everyone, and welcome to this Pedscases podcast on female genital cutting, or FGC. My name is Dora Gyenes and I'm a 3rd year medical student at the University of Alberta. This podcast was developed together with Dr. Cathy Flood, who is a urogynecologist at the Royal Alexandra Hospital in Edmonton, Alberta with expertise in FGC and its reconstructive surgery. Our goal is to give you an overview of FGC and some suggestions for how to discuss it with families.

Objectives:

We hope that by the end of this podcast you will be able to:

1. Discuss the what, where, and why of FGC, as well as some of the current trends in its practice.
2. Discuss the immediate and long-term complications of FGC.
3. Detail how FGC is addressed in Canadian law.
4. Develop an approach to discussing FGC with patients and families coming from countries where it is prevalent, keeping in mind some cultural considerations.
5. Develop an approach to a pelvic exam in a child who has been cut.

Clinical Case:

Let's start with a clinical case to put everything into context:

You are a medical trainee working at a general pediatrics practice in Edmonton. The first appointment of the day is a meet-and-greet with a new patient, 4-year-old Ada, whose family immigrated to Canada just 1 month ago from Somalia. She is accompanied by her mother, father, 13-year-old sister, and 6-year-old brother. You've heard the term "female genital mutilation" in the news before and recognize that it is

practiced commonly in Somalia and you wonder whether this is something that is appropriate to ask Ada's family about? How do you go about starting the conversation?

Background Information:

Before we get to all of that, let's take a step back and talk about what FGC is and where in the world it's commonly performed:

First of all, let's discuss the terminology. Female genital mutilation, female genital cutting, and female circumcision are all terms that have been used to describe the same procedure[1]. You'll often hear different terms depending on if you're speaking to a healthcare professional, women who have been cut, or even between different sources in the literature. All these terms are used, and it's often most appropriate to mirror the language the patient uses to describe their own experience[2]. Throughout this podcast, we will preferentially be using the term female genital cutting, abbreviated as FGC.

The procedure of FGC is defined by the World Health Organization[3] as: "all procedures involving partial or total removal of female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons."

The WHO describes a classification system for FGC which has been widely adopted and is based on how much tissue is removed[4]. It defines 4 distinct types of FGC:

- Type 1 involves excision of the prepuce (also known as the clitoral hood) and/or the partial or total removal of the clitoris glans, which is the external and visible part of the clitoris
- Type 2, which makes up 80% of women who have been cut, is the partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora
- Type 3 is done on 15% of women and is also called infibulation. This type involves narrowing the vaginal opening by cutting and/or stitching the labia minora or labia majora to create a neointroitus, or a new vaginal opening. Type 3 cutting can also include a partial or total removal of the clitoris. This type is commonly seen by healthcare providers due to the high rate of complications seen later in life[5, 6].
- Type 4 is described as a ceremonial cutting, and involves procedures such as pricking, piercing, incising, scraping, or cauterizing the female genitalia for non-medical reasons. This type of cutting is often harder to recognize on physical exam.

FGC is most prevalent in Sub-Saharan Africa and the Middle East, and specifically, the countries with a greater than 80% prevalence of the practice are: Somalia, Guinea, Djibouti, Egypt, Eritrea, Mali, Sierra Leone, and Sudan[1]. In fact, in Somalia, where Ada's family is from, FGC has a prevalence of up to 98%. However, we know immigration has increased internationally, so while this practice may have originated elsewhere, it is now a topic that Canadian healthcare practitioners should be familiar with, as demonstrated by our case. The data is lacking for knowing how commonly the practice is performed among newcomers to Canada, but we know that support for the procedure varies[1].

FGC is done on young girls all the way from birth to age 15, although the Canadian Pediatric Society[1] found that in half of the 29 countries where FGC is most prevalent, 80% of cutting is done before the age of 5. FGC is often performed by female family members on several girls at a time in a ceremonious fashion[5, 6]. It is estimated that more than 200 million women and girls who are currently alive have had FGC performed on them in the countries where it is most common[4]. Girls are more likely to be cut if their mother was cut herself, or if the mother has no education[1].

Numerous agencies, including the World Health Organization, the Society of Obstetricians and Gynecologists of Canada, and the American College of Obstetricians and Gynecologists state that FGC is recognized worldwide as a human rights violation, that it represents an extreme form of discrimination against women, and that it is the manifestation of deep-rooted inequality between the sexes[1, 2, 6, 7, 8].

Canadian law addresses the topic of FGC specifically. Performing FGC or assisting with it in any way is illegal, and the person can be charged with aggravated assault[2]. Taking children out of Canada to have the procedure performed in another country, such as their home country, is also a criminal offense. For healthcare professionals, it's crucial to know that FGC is recognized as a form of childhood physical abuse, and as such should be reported to your local Child and Family Welfare Service[2].

So how has the practice of FGC been evolving over the years? The overall prevalence of FGC has decreased over the last 30 years, but the rate of decline differs depending on which country is examined[4]. Some countries have made little progress to decrease the prevalence of the practice and move towards eradication. Another interesting trend that has been reported is that FGC is becoming more medicalized, meaning that it is performed in hospitals by healthcare professionals. In Egypt, for example, up to 77% of FGC is performed by a doctor, nurse, midwife, or other healthcare provider[1]. While some providers believe this makes FGC safer, and thus is a step towards eradicating

the practice, it has been argued that medicalization legitimizes and normalizes the practice[4]. Because of this, the WHO is against FGC in all its forms, including when performed in a hospital, and it urges practitioners to consider how the practice violates the core medical ethical value of “do no harm”.

Complications:

FGC has no medical benefit, and has multiple risks and complications associated with it[4].

During the procedure, the tools used are often heated stones, knives, scissors, or razor blades that are not properly sterilized[2, 4, 5, 6]. Anaesthesia is often not used unless done in a hospital[5, 6]. There is a risk of severe pain as the nerve endings are severed, as well as when the nerve endings heal[4]. Hemorrhage is a risk if the clitoral artery or another vessel is severed.

Immediately post-procedure, the lack of sterility places girls at an increased risk of infections including HIV[5, 6]. Genital swelling can occur as a local inflammatory response, which can lead to urinary retention and dysuria[4]. Urinary complications can occur from injury to the urethra during the procedure. Shock can occur from several causes, such as pain, hemorrhage, or infection leading to sepsis. Death is also a potential complication of FGC[2, 4].

Long term physical and sexual complications of FGC can include: chronic pelvic pain, dysuria, dysmenorrhea, anorgasmia and dyspareunia[4]. In severe cases, girls are unable to pass urine or menstrual products[5, 6]. In addition, it has been shown that girls and women who have undergone FGC are at an increased risk of contracting repeated urinary tract infections[4]. Obstetrical complications have been documented, including the increased risks of C-section delivery and obstetrical lacerations during vaginal delivery. Dr. Flood recalled seeing patients with such severe obstetrical lacerations from scar tissue that it resulted in loss of the vagina entirely.

The psychological effects of FGC should also be considered. Women who undergo FGC are more likely to struggle with anxiety or PTSD later in life, as well as develop low self-esteem, somatization, or specific phobias[9].

Why Is It Done?:

If there is no medical benefit, why does FGC continue to be done?

It isn't entirely clear where the practice of FGC originated, as it does not appear in any religious texts, and support for it varies among religious leaders[4, 5, 6].

There are several commonly reported reasons: first, FGC is thought to preserve a girl's chastity until marriage by both reducing her libido (so that she can refrain from engaging in extramarital sex), as well as ensuring that her husband can be the one to "open her" on their wedding night, meaning that he widens the vaginal opening by cutting or stretching the tissue[4, 5, 6]. These reasons reflect what these communities consider to be proper sexual practices, and they emphasize modesty and chastity[4]. In many communities, FGC is considered a rite of passage and upheld as a social norm, so girls feel pressured to undergo the procedure in order to be socially accepted and to improve their marriage prospects[4, 5, 6]. In other groups, it is considered favourable to remove the "unclean" parts of a woman's body such as the clitoris, which can be considered to be masculine[4]. Finally, many communities argue that FGC is a deep-rooted tradition, which for some is enough of an argument to continue the practice[4].

Recommendations:

Now that we've covered some of the background of what FGC is and why it's done, the next step is to discuss, how should Canadian practitioners handle the topic of FGC when it comes up in their practice?

First of all, in order to be able to have informed conversations about FGC with families, healthcare providers must first familiarize themselves with the basics of what it is, what the physical and psychological consequences are, and what the laws relating to it are in your jurisdiction[1, 2].

The World Medical Association Statement on Female Genital Mutilation[10] recommends using a culturally competent approach to explain the risks associated with the procedure, and to discourage families from performing it on their daughters. Some of the goals of these conversations include gauging how much the families understand about FGC and whether or not they support the practice[1]. If they aren't already aware, the family should also be counselled about the illegality of FGC in Canada as well as its risks[2].

Whether or not you decide to have a conversation about FGC with the whole family, or just the parents, or just the child, will be a clinical judgement that you make based on the family in front of you and the age of the child. For example, with adolescents, you will likely want to address FGC when you speak to them on their own, whereas for a prepubescent child, that conversation could be embarrassing or even traumatizing for them and you may decide to speak with the parents first.

When taking a history, doing a physical exam, or counselling families, it is important to be respectful and non-judgemental of their views and beliefs[1]. It's reasonable to offer a genital exam as part of a screening physical exam, if your clinical judgement determines it's indicated. In pediatric populations, inspection of the vulva, clitoris, and urethral meatus is often sufficient to be able to determine the type of FGC that the patient has undergone, as well as if there are any associated complications such as scarring or cysts[8]. You should be familiar with what the various types of FGC look like on exam so that you can recognize them in your patients. The Canadian Pediatric Society has some very helpful pictorial examples of what the various types of FGC look like on exam in their guide to assessment and screening[1]. The link for that webpage and the visual can be found in the script to this podcast (https://www.kidsnewtocanada.ca/screening/fgm). The findings of your physical exam and the child's cutting status, including the type of cutting they've had, if any, should be documented in their chart to avoid the need for repeat physical exams and questioning of the family[2].

Speculum exams may be quite difficult and traumatizing in patients with Type 3 FGC[5]. If the exam is indicated and necessary, small speculums should be available and used, though some patients may require an examination under anesthesia [5, 8]. Consider instead using pelvic ultrasound as a way to investigate gynecologic complaints in patients who have been cut. It should be noted that an internal exam would be contraindicated in a pre-pubertal patient. The trauma and pain it causes along with how little it changes clinical management means speculum exams are rarely, if ever, necessary in this population[11].

It's important to recognize that suspecting FGC is a reason to break confidentiality with a patient or family, as that child is at risk of having a harmful and illegal procedure performed on them[10]. As previously mentioned, suspecting that a child is at risk of FGC

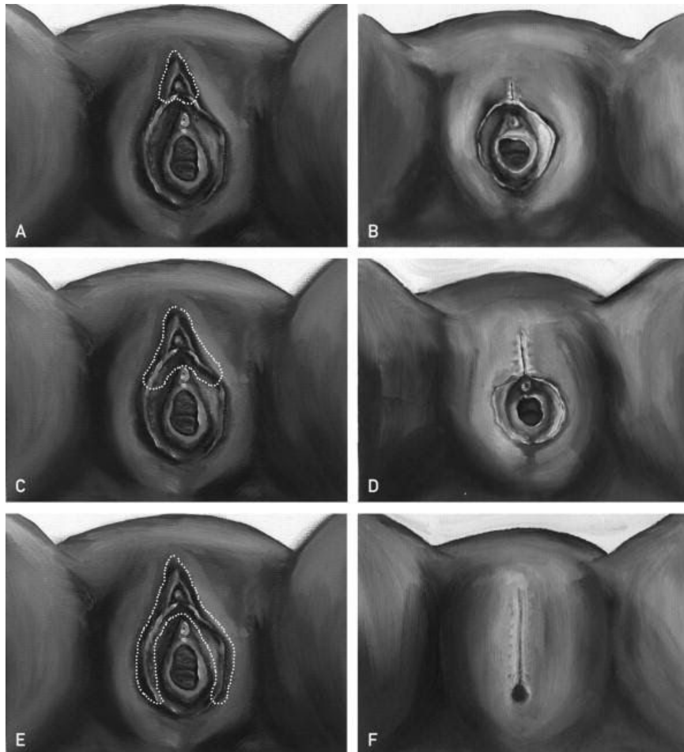

Figure 2. *Types of female genital cutting (FGC). A, Tissue removed in type 1 FGC: partial or total removal of the clitoris and/or the prepuce (clitoridectomy). B, Appearance after type 1 FGC. C, Tissue removed in type 2 FGC: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). D, Appearance after type 2 FGC. E, Tissue removed in type 3 FGC: narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). F, Appearance after type 3 FGC. Illustrations reproduced with permission from the artist, Jessica Stanton, MD. © 2013 Mayo Foundation for Medical Education and Research*

or that they have been subjected to it either in Canada or in another country is reason to report to Child and Family Services[2].

A study done by the National Institute for Health Research in the UK found that stigma, shame, and silence underpinned many of the healthcare encounters of women who had undergone FGC[12]. This is a major barrier to accessing care, particularly for non-pregnant women. Women found these experiences to be “emotionally distressing and disempowering”. Women’s experiences were more positive when they interacted with a trusted healthcare provider who possessed both knowledge about the issue and a culturally sensitive approach to it. Making sure that interpreters are available when needed, and that there are clear guidelines in place for referral to mental health and specialist services can improve care related to FGC.

Some special considerations when working with adolescents who have been cut are outlined by the SOGC in their Clinical Practice Guideline for FGC[2]. Requests for reconstructive surgery should not be denied to adolescents, as long as there has been a thorough discussion about the physical and psychological risks and benefits. Discussions about contraception, STI prevention, and making healthy sex choices are always appropriate, regardless of cutting status.

It's also important to consider that these conversations about FGC can be prudent no matter the patient's cutting status[2]. Immigrant communities can sometimes feel "double the shame of being different" when it comes to FGC. They can feel shame from their home country for not having the procedure done, and shame from their new country if they have had it done. That's why it's so important to remain non-judgemental and open with families, since one never knows what their personal circumstances are.

Back to the Case:

Now that we've gone through how healthcare providers might approach a discussion about FGC, how can we provide the best care to Ada and her family?

First, we need to gauge if Ada's family is willing to discuss the topic with you, and this could be done with a phrase such as: "Would you be open to discussing female genital cutting and how your community and family view it?"

If they say yes, you can ask: "Has anyone in your family been cut? If so, what term do you prefer to use?[8]" We want to make sure we're reflecting the language that Ada's parents use, and by potentially finding out if her mother was cut, this will help us determine if Ada might be at an increased risk herself.

You could also discuss with them what their understanding is of the physical and psychological risks of FGC.

If you feel it's appropriate, you could also ask them directly: "How would you feel if your daughter was cut?"

If they indicate an interest in having Ada cut, you could counsel them on what that might mean for them here in Canada. For example: "I'm not sure if you're aware of this, but female genital cutting is a reportable offense in Canada, just like the physical abuse of a

child is. That means that if I suspected Ada was at risk of being cut, I would have to tell someone. Does that affect your plans at all?[8]" Of course, use your judgement to determine how the family-provider relationship might be harmed with these more direct questions, and make adjustments as needed.

In our case, the family tells you that while Ada's mother was cut when she was 5 years old, as was their older daughter back in Somalia, they are aware that FGC is illegal in Canada and have no plans to have Ada cut.

In our case, the family was open to talking about FGC right at the first visit, but know that this discussion might not be something that happens all at once. It can take time for a family to build a trusting relationship with you so that they feel comfortable discussing their views on cutting and their plans for their daughters. Remain open and free of judgement, while still being clear that the practice of female genital cutting is not supported in Canada or by the World Health Organization, and that it should not be done on Ada or any other child.

Key Learning Points:

Okay, so now let's recap the key takeaways we've learned before we wrap up our discussion.

1. Female genital cutting is a practice originating mainly in Sub-Saharan Africa where some or all of the female external genitalia is removed for non-medical reasons. Recently, while overall rates have decreased, the increasing medicalization of FGC is counterproductive to efforts to eradicate it. With increasing immigration worldwide, FGC is a topic all healthcare providers should be somewhat familiar with.

2. FGC has no medical benefit and numerous complications, including short term risks such as infection, hemorrhage, and pain, as well as long term risks such as urinary issues, menstrual issues, and psychological distress.

3. FGC is illegal in Canada, as is facilitating it in any way like removing children from the country to have the procedure done elsewhere.

4. Each family has different circumstances and views about female genital cutting, and they can feel shame and guilt from different groups no matter their stance. For this reason, these conversations should be approached with nuance, respect, and

understanding. When discussing FGC with patients and families, bring it up in a non-judgemental, caring way, and ask if they are willing to talk about it with you. Determine their preferred term, their views on the topic, and their understanding of: the procedure itself, its risks, and its illegality in Canada. Use interpretation services if needed.

5. If a vaginal exam is indicated in a child who has been cut, inspect the vulva, clitoris, and urethral meatus to ascertain the type of cutting that has been done and any potential complications. Know what the various types of FGC look like on exam so that you can classify them accurately.

And with that, we have reached the end of the podcast. We hope you found it informative and useful to you in some way. Thanks so much for listening!

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